AMENDED IN ASSEMBLY JANUARY 4, 2006

CALIFORNIA LEGISLATURE—2005–06 REGULAR SESSION

ASSEMBLY BILL No. 1554

Introduced by Assembly Member Frommer

February 22, 2005

~~An act to amend Section 657 of the Insurance Code, relating to auto insurance.~~ *An act to amend Sections 62.5, 4062.3, 5307.1, and 6434 of the Labor Code, relating to workers' compensation.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1554, as amended, Frommer. ~~Auto insurance: refusals.~~ *Workers' compensation.*

Existing workers' compensation law requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, or in the course of, employment.

This bill would make various technical, nonsubstantive, and clarifying changes to these provisions.

~~Existing law requires that, when any admitted insurer licensed to issue motor vehicle liability policies, or any licensed insurance agent, refuses to accept an application for such a policy or refuses to issue such a policy when a written application has been made, the refusing agent or insurer furnish to the applicant, if requested, a written statement explaining the reasons relied upon for that action. Existing law provides that a violation of this provision is a misdemeanor and is punishable by a fine not exceeding $1,000 for each violation.~~

~~This bill would raise the amount of the fine to $1,500 for each violation.~~

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 62.5 of the Labor Code is amended to read:

62.5. (a) The Workers' Compensation Administration Revolving Fund is hereby created as a special account in the State Treasury. Money in the fund may be expended by the department, upon appropriation by the Legislature, for the administration of the workers' compensation program set forth in this division and Division 4 (commencing with Section 3200), other than the activities financed pursuant to Section 3702.5, and the Return-to-Work Program set forth in Section 139.48, and may not be used or borrowed for any other purpose.

(b) The fund shall consist of surcharges made pursuant to subdivision (e)*, and from fees, penalties, and other amounts collected pursuant to Sections 129, 129.5, 139.2, 4610, 4628, 4903.05, and 6434*.

(c) (1) The Uninsured Employers Benefits Trust Fund is hereby created as a special trust fund account in the State Treasury, of which the director is trustee, and its sources of funds are as provided in subdivision (e). Notwithstanding Section 13340 of the Government Code, the fund is continuously appropriated for the payment of nonadministrative expenses of the workers' compensation program for workers injured while employed by uninsured employers in accordance with Article 2 (commencing with Section 3710) of Chapter 4 of Part 1 of Division 4, and shall not be used for any other purpose. All moneys collected shall be retained in the trust fund until paid as benefits to workers injured while employed by uninsured employers. Nonadministrative expenses include audits and reports of services prepared pursuant to subdivision (b) of Section 3716.1. The surcharge amount for this fund shall be stated separately.

(2) Notwithstanding any other provision of law, all references to the Uninsured Employers Fund shall mean the Uninsured Employers Benefits Trust Fund.

(3) Notwithstanding paragraph (1), in the event that budgetary restrictions or impasse prevent the timely payment of administrative expenses from the Workers' Compensation Administration Revolving Fund, those expenses shall be

advanced from the Uninsured Employers Benefits Trust Fund. Expense advances made pursuant to this paragraph shall be reimbursed in full to the Uninsured Employers Benefits Trust Fund upon enactment of the annual Budget Act.

(d) (1) The Subsequent Injuries Benefits Trust Fund is hereby created as a special trust fund account in the State Treasury, of which the director is trustee, and its sources of funds are as provided in subdivision (e). Notwithstanding Section 13340 of the Government Code, the fund is continuously appropriated for the nonadministrative expenses of the workers' compensation program for workers who have suffered serious injury and who are suffering from previous and serious permanent disabilities or physical impairments, in accordance with Article 5 (commencing with Section 4751) of Chapter 2 of Part 2 of Division 4, and Section 4 of Article XIV of the California Constitution, and shall not be used for any other purpose. All moneys collected shall be retained in the trust fund until paid as benefits to workers who have suffered serious injury and who are suffering from previous and serious permanent disabilities or physical impairments. Nonadministrative expenses include audits and reports of services pursuant to subdivision (c) of Section 4755. The surcharge amount for this fund shall be stated separately.

(2) Notwithstanding any other provision of law, all references to the Subsequent Injuries Fund shall mean the Subsequent Injuries Benefits Trust Fund.

(3) Notwithstanding paragraph (1), in the event that budgetary restrictions or impasse prevent the timely payment of administrative expenses from the Workers' Compensation Administration Revolving Fund, those expenses shall be advanced from the Subsequent Injuries Benefits Trust Fund. Expense advances made pursuant to this paragraph shall be reimbursed in full to the Subsequent Injuries Benefits Trust Fund upon enactment of the annual Budget Act.

(e) (1) Separate surcharges shall be levied by the director upon all employers, as defined in Section 3300, for purposes of deposit in the Workers' Compensation Administration Revolving Fund, the Uninsured Employers Benefits Trust Fund, and the Subsequent Injuries Benefits Trust Fund. The total amount of the surcharges shall be allocated between self-insured employers and insured employers in proportion to payroll respectively paid in

the most recent year for which payroll information is available. The director shall adopt reasonable regulations governing the manner of collection of the surcharges. The regulations shall require the surcharges to be paid by self-insurers to be expressed as a percentage of indemnity paid during the most recent year for which information is available, and the surcharges to be paid by insured employers to be expressed as a percentage of premium. In no event shall the surcharges paid by insured employers be considered a premium for computation of a gross premium tax or agents' commission. In no event shall the total amount of the surcharges paid by insured and self-insured employers exceed the amounts reasonably necessary to carry out the purposes of this section.

(2) The regulations adopted pursuant to paragraph (1) shall be exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 2. Section 4062.3 of the Labor Code is amended to read:

4062.3. (a) Any party may provide to the qualified medical evaluator selected from a panel any of the following information:

(1) Records prepared or maintained by the employee's treating physician or physicians.

(2) Medical and nonmedical records relevant to determination of the medical issue.

(b) Information that a party proposes to provide to the qualified medical evaluator selected from a panel shall be served on the opposing party 20 days before the information is provided to the evaluator. If the opposing party objects to consideration of nonmedical records within 10 days thereafter, the records shall not be provided to the evaluator. Either party may use discovery to establish the accuracy or authenticity of nonmedical records prior to the evaluation.

(c) If an agreed medical evaluator is selected, as part of their agreement on an evaluator, the parties shall agree on what information is to be provided to the agreed medical evaluator.

(d) In any formal medical evaluation, the agreed or qualified medical evaluator shall identify the following:

(1) All information received from the parties.

(2) All information reviewed in preparation of the report.

(3) All information relied upon in the formulation of his or her opinion.

(e) All communications with an agreed medical evaluator or a qualified medical evaluator selected from a panel before a medical evaluation shall be in writing and shall be served on the opposing party 20 days in advance of the evaluation. Any subsequent communication with the medical evaluator shall be in writing and shall be served on the opposing party when sent to the medical evaluator.

(f) Ex parte communication with an agreed medical evaluator or a qualified medical evaluator selected from a panel is prohibited. If a party communicates with the agreed medical evaluator or the qualified medical evaluator in violation of subdivision (e), the aggrieved party may elect to terminate the medical evaluation and seek a new evaluation from another qualified medical evaluator to be selected according to Section 4062.1 or 4062.2, as applicable, or proceed with the initial evaluation.

(g) The party making the communication prohibited by this section shall be subject to being charged with contempt before the appeals board and shall be liable for the costs incurred by the aggrieved party as a result of the prohibited communication, including the cost of the medical evaluation, additional discovery costs, and attorney's fees for related discovery.

(h) Subdivisions (e) and (f) shall not apply to oral or written communications by the employee or, if the employee is deceased, the employee's dependent, in the course of the examination or at the request of the evaluator in connection with the examination.

(i) Upon completing a determination of the disputed medical issue, the medical evaluator shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator.

(j) If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical

evaluator who prepared the previous evaluation to resolve the medical dispute.

(k) No disputed medical issue specified in ~~subdivision (a)~~ *Section 4060, 4061, or 4062* may be the subject of declaration of readiness to proceed unless there has first been an evaluation by the treating physician or an agreed or qualified medical evaluator.

SEC. 3. Section 5307.1 of the Labor Code is amended to read:

5307.1. (a) The administrative director, after public hearings, shall adopt and revise periodically an official medical fee schedule that shall establish reasonable maximum fees paid for medical services other than physician services, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section. Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in ~~subdivisions (k) and (*l*)~~ *subdivision (j)*, maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision ~~(c)~~ *(g)*, except that for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be 100 percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision ~~(c)~~ *(g)*. Pharmacy services and drugs shall be subject to the

requirements of this section, whether furnished through a pharmacy or dispensed directly by the practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

(b) In order to comply with the standards specified in subdivision (f), the administrative director may adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

(c) Notwithstanding subdivisions (a) and (d), the maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, may not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.

(d) If the administrative director determines that a medical treatment, facility use, product, or service is not covered by a Medicare payment system, the administrative director shall establish maximum fees for that item, provided that the maximum fee paid shall not exceed 120 percent of the fees paid by Medicare for services that require comparable resources. If the administrative director determines that a pharmacy service or drug is not covered by a Medi-Cal payment system, the administrative director shall establish maximum fees for that item~~, provided, however, that~~ . *However,* the maximum fee paid shall not exceed 100 percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

(e) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, or, with regard to pharmacy services and drugs, for a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003.

(f) Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

(g) (1) (A) Notwithstanding any other provision of law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, provided that both of the following conditions are met:

(i) The annual inflation adjustment for facility fees for inpatient hospital services provided by acute care hospitals and for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

(ii) The annual update in the operating standardized amount and capital standard rate for inpatient hospital services provided by hospitals excluded from the Medicare prospective payment system for acute care hospitals and the conversion factor for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for excluded hospitals for the 12 months beginning October 1 of the preceding calendar year.

(B) The update factors contained in clauses (i) and (ii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2003.

(2) The administrative director shall determine the effective date of the changes, and shall issue an order, exempt from Sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section ~~11370~~ *11340*) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date. All orders issued pursuant to this paragraph shall be published on the Internet Web site of the ~~division~~ *Division* of Workers' Compensation.

(3) For the purposes of this subdivision, the following definitions apply:

~~(A) "Medicare Economic Index" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of a providing physician and other services paid under the resource-based relative value scale.~~

~~(B)~~

(A) "Hospital market basket" means the input price index used by the federal Centers for Medicare and Medicaid Services to

measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included in the Medicare prospective payment system.

~~(C)~~

(B) "Hospital market basket for excluded hospitals" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient services by hospitals that are excluded from the Medicare prospective payment system.

(h) Nothing in this section shall prohibit an employer or insurer from contracting with a medical provider for reimbursement rates different from those prescribed in the official medical fee schedule.

(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.

(j) The following Medicare payment system components may not become part of the official medical fee schedule until January 1, 2005:

(1) Inpatient skilled nursing facility care.

(2) Home health agency services.

(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals.

(4) Outpatient renal dialysis services.

(k) Notwithstanding subdivision (a), for the calendar years 2004 and 2005, the existing official medical fee schedule rates for physician services shall remain in effect, but these rates shall be reduced by 5 percent. The administrative director may reduce fees of individual procedures by different amounts, but in no event shall the administrative director reduce the fee for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure.

(*l*) Notwithstanding subdivision (a), the administrative director, commencing January 1, 2006, shall have the authority, after public hearings, to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services. If the administrative director fails to adopt an official medical fee schedule for physician services by January 1, 2006, the existing official medical fee schedule rates for physician

services shall remain in effect until a new schedule is adopted or the existing schedule is revised.

SEC. 4. Section 6434 of the Labor Code is amended to read:

6434. (a) Any civil or administrative penalty assessed pursuant to this chapter against a school district, county board of education, county superintendent of schools, charter school, community college district, California State University, University of California, or joint powers agency performing education functions shall be deposited ~~with~~ *in* the ~~Workplace Health and Safety Revolving~~ *Workers' Compensation Administration Revolving* Fund established pursuant to Section ~~78~~ *62.5*.

(b) Any school district, county board of education, county superintendent of schools, charter school, community college district, California State University, University of California, or joint powers agency performing education functions may apply for a refund of their civil penalty, with interest, if all conditions previously cited have been abated, they have abated any other outstanding citation, and if they have not been cited by the division for a serious violation at the same school within two years of the date of the original violation. Funds not applied for within two years and six months of the time of the original violation shall be expended as provided for in Section ~~78 to assist schools in establishing effective occupational injury and illness prevention programs~~ *62.5*.

~~SECTION 1. Section 657 of the Insurance Code is amended to read:~~

~~657. (a) When any admitted insurer, licensed to issue motor vehicle liability policies as defined in Section 16450 of the Vehicle Code, or any licensed insurance agent refuses to accept an application for such a policy or refuses to issue such a policy when a written application has been made, the refusing agent or refusing insurer shall furnish to the applicant for insurance a written statement explaining the reason or reasons relied upon for that action if within 30 days after that refusal the applicant requests in writing, from the agent or insurer who has refused to accept the application or to issue the policy, a written explanation. The statement shall be furnished within 30 days of receipt of the request.~~

~~(b) Any insurer or agent willfully violating any provisions of this section is guilty of a misdemeanor and is punishable by a fine not exceeding one thousand five hundred dollars ($1,500) for each violation thereof.~~

~~(c) There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Insurance Commissioner or against any insurer, its authorized representative, its agents, its employees, or any firm, person or corporation furnishing to the insurer information as to the reasons for such a refusal, for any statement made by any of them in any written notice of reasons for refusing to accept the application or issue the policy or in any other communication, oral or written, specifying the reasons for such action or the providing of the information pertaining thereto, or for statements made or evidence submitted in any hearings conducted in connection therewith.~~

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